pancreas! They were immune, not to pancreatic substance but to poison contained in the inflamed organ.

URINARY ORGANS.

I. Treatment of Intra-Peritoneal Bladder Tears without Bladder Suture. NEUMANN (Mainz).—The results in laparotomy and suture are not good. There is a growing suspicion that the peritonitis which causes death may be caused by operation. Neumann reports a case where suture had to be abandoned because of collapse and was replaced by a tampon the size of the fist. Twenty hours after some urine was passed naturally. Complete cure. The tampons must not be so large as to compromise the bladder.

EXTREMITIES.

I. Socket Resection in Hip-Joint Disease. BARDENHEUER (Cologne).—To determine the condition of the socket he palpates by finger the inner surface of the pelvis, lifting up the psoas. It is usually found to be diseased because of the lateness of the operation and its resection or curettage shortens much the convalescence. It also enables one to reach all the tuberculous tissue. The real shortening is slight and is compensated in the inclination of the pelvis and the abduction of the femur.

The fourth advantage is that the operation prevents the development of adduction-flexion and the wandering of the femur head past the pelvis.

The fifth, that there usually forms a strong movable union (twice in seven a bony union).

Sixth, good function. The dangers are not greater, and when we consider the lamentable results of the incomplete operation, really less. Of course resection of the socket is combined with excision of the head of the femur, etc.

SPRENGEL has repeatedly used this method (Bardenheuer's), but he does not go so far as Bardenheuer, who attacks the socket in relatively early cases. The attack is

too severe. It should be reserved for late cases and the young, not for the old.

II. On the Voluntary Luxation of the Hip-Joint. BRAUN (Göttingen).—Only twenty cases have been reported and this the first operative. The girl can dislocate the hip partly voluntarily by straining certain muscles, or in walking it may occur spontaneously. The luxation is incomplete and outward, and is accompanied by a loud crack and great pain. The unbearable trouble was operated upon after rest, extension and gypsum failed. No cartilaginous antrum was found, leaving the socket shallow. A piece 2 by 5 or 6 cm. was chiselled from the upper hinder edge of the bony socket, displaced downward, and fixed. Plaster of Paris dressing. Primary union. Complete cure after two and one-quarter years. The method is recommended for repeated spontaneous luxation when depending on similar basis.

III. On the Fate of Silver Wire in Open Suture of the Broken Patella. VON BRUNS (Tübingen).—Of twelve cases, in only one was bony union reached without tearing out or breaking. In three cases pieces of wire reached the capsule. Bony union occurred in three cases, but in two more Röntgen examination showed slight separation. The harm from the wire does not reach to compromising the healing. Patients frequently complained of sticking pain. Complete extension usually followed.

KRÖNLEIN is not convinced that the open method is better than the closed.

KÜSTER recommended the percutaneous suture.

RIEDEL recommended the subcutaneous suture with catgut, and with 10 to 12 such the fragments could be very closely lashed together.

VON BRUNS is not satisfied with the results. A good anatomical healing is not identical with good functional cure, and the converse.

BARDENHEUER obtains by extension at least a good fibrous union.

IV. On Bone Implantation. RAUSCH (Schoneberg) demonstrated the largest (up to this time) piece of dead bone implanted in bone and healed. A piece 9 cm. long and the thickness of the whole tibia was obtained from an amputation the day before, boiled and placed in the upper end of the tibia which had been resected for myelogenous sarcoma. Secured to femur and tibia by ivory pegs. Primary union. Nine months later, amputation for recurrence.

The implanted piece had grown fast on both sides, was nourished and covered by new periosteum.

V. On the Rational Ambulant Treatment of Varicose Veins and Ulcers of the Leg. LOSSEN (Frankfort a. M.).—The cause was mostly in the inactivity or weakness of the musculature of the lower extremity. Previous forms of treatment have at most only a temporary result and instead of considering this chief cause one still prescribes rest and elevation. The trouble quickly returns. Instead of weakening still more the musculature through disuse it should be put in condition again by gymnastics, massage, etc. Lossen has treated several smiths without interrupting their work, by showing them ten to twenty times how to do during their work the required gymnastics. After four to six weeks the swelling was gone and the ulcers healed. He has also had good results in the *praxis elegans*.

VI. Osteoplastic Resection of the Tibia and Ankle-Joint. BRODNITZ (Frankfort a. M.).—Adaptable to advanced tuberculosis of the lower third of the tibia and ankle-joint, especially tumors of the lower third of the tibia. Longitudinal incision over tibia and over fibula to the talo-navicular joint; connecting the upper ends of these by a bow-shaped incision down to the bones, and the lower ends by an oval incision over the tuberosity of the calcaneus, also to the bones. Oblique division of tibia and fibula by Gigli saw and the calcaneus by a metacarpal saw, the soft parts correspondingly. Shell out the anterior soft parts and adapt the calcaneus to the tibia.

VII. On the Plastic Covering of Exarticulation Stumps. SAMTER (Königsberg i. Pr.).—Both feet of a child were crushed, the soft parts above the malleoli. The malleoli were sawed off, a bridge-shaped flap was made from behind the lower end of the tibia and slid down under the defect like a stirrup. The rest healed by granulation. The result for some time has been good, movable soft parts and a supportive stump.